DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1 0

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 7,037
b. FFY 2001 $21,242

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages 2b, 3, 4, 5, and 6
Supplement 1 to Attachment 4.19-D, pages 1 through 16
Supplement 2 to Attachment 4.19-D, pages 9, 10, 24, 25, and 26

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, page 2b (MS-00-8), page 3 (MS-90-3) pages 4 and 5 (MS-99-9) and page 6 (MS-94-38)
Supplement 1 to Attachment 4.19-D, pages 1 through 16 (MS-99-10)
Supplement 2 to Attachment 4.19-D, pages 9, 10, 24, 25, and 26 (MS-99-10)

10. SUBJECT OF AMENDMENT:
Changes in reimbursement limits and methodology for nursing facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jessie K. Rasmussen

13. TYPED NAME:
Jessie K. Rasmussen

14. TITLE:
Director

15. DATE SUBMITTED:
August 17, 2000

16. RETURN TO:
Director
Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
08/21/00

18. DATE APPROVED:
NOV 9 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 1 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Rasmussen
Headlee
CO

SPA CONTROL

Date Submitted 08/17/00
Date Received 08/21/00

FORM HCFA-179 (07-92)

Instructions on Back

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Nursing Facilities That Provide Skilled Care (Cont.)

8. Exceptions to the Rate-Setting Process (Cont.)

b. Ventilator Incentive

A special incentive to care for ventilator-dependent patients is added to a facility's rate if a patient meets the requirements for skilled and ventilator care. The facility will receive the maximum allowable cost for the type of facility plus an additional $100 per day

For a patient successfully weaned off the respirator, the incentive payment will continue for 30 days.

c. Case-Mix Factor

A semi-annual case mix factor is applied to the payment rates for the free-standing facilities. Facilities with a case mix index derived from the Minimum Data Set (MDS) reports that exceeds the Iowa nursing facility average for all participating nursing facilities receive an addition to their payment rate of $5.20 per day.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Nursing Facilities That Provide Skilled Care (Cont.)

8. Exceptions to the Rate-Setting Process (Cont.)

d. Fraud and Abuse

When fraud or abuse has been verified, the facility's prospective reimbursement rate shall be adjusted. If the facility's base year per diem is subsequently determined to have been based on false or misleading information, an appropriate adjustment shall be made to the base year rate and all resulting overpayments shall be recouped. Such adjustments do not preclude other sanctions authorized by statute or regulation.

9. Lower Level of Care

Payment for residents who are determined by utilization review to require the regular nursing facility level of care shall be made at the statewide average medical assistance nursing facility rate. This rate is effective as of the final notice by utilization review that the lower level of care is required.

10. Revaluation of Assets

The provisions of Section 1902(a)(13)(c) of the Social Security Act shall be followed.

11. Provider Appeals

In accordance with 42 CFR 447.253(c), if a provider of service is dissatisfied with the determination of the base year allowable cost, the provider may file an appeal and request reconsideration from the Administrator of the Division of Medical Services in the Department. The appeal must be in writing, clearly state the nature of the appeal, and be supported with all relevant data.

The Administrator of the Division of Medical Services will review the material submitted, render a decision and advise the provider accordingly within a period of 90 days.

12. Cost Reporting

Each participating facility must file a uniform cost report. The reporting forms used in Medicare are also used in Medicaid.

13. Audits

Each participating facility is subject to a periodic audit of its fiscal and statistical records.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

B. Nursing Facilities That Provide Intermediate Care, Including Intermediate Care for People with Mental Illness Aged 65 and Older

1. Introduction

Nursing facilities that are not certified by Medicare to provide the skilled level of care receive Medicaid reimbursement based on a prospective per diem rate calculated for each facility, which may then be increased by a case mix factor as described in 2e.

These facilities complete form 470-0030, *Financial and Statistical Report*, to report their actual costs. A sample of this form is Supplement 1 to Attachment 4.19-D.

The Department's methods for analyzing these reports and setting facility rates are described in Supplement 2 to Attachment 4.19-D.

Accounting procedures, including designation of classes, setting the maximum allowable cost ceiling, and setting the inflation and incentive factors also follow. Methods for the rate adjustment for the costs of meeting nursing home reform requirements are described.

2. Accounting Procedures

a. Designation of Classes of Nursing Facilities That Provide Intermediate Care

Two classes of providers are recognized for nursing facilities that provide intermediate care. These are "state-owned" and "non-state-owned" nursing facilities, including facilities for the mentally ill for residents aged 65 and older.

Costs for each class are analyzed separately, but under a common procedure.

b. Maximum Allowable Rate Ceiling

The Department shall pay 100 percent of a facility's cost until such time as there are eight facilities in a class.

If there are eight or more facilities in a class, the maximum per diem reimbursement rate is determined at a level where 70 percent of participating facilities are receiving full coverage of their cost. If no facility is at the exact 70th percentile, the rate used is that of the facility closest to but not exceeding the 70th percentile. This rate is referred to as the 70th percentile maximum rate.

Facilities eligible for the addition of a case-mix factor to their payment rate shall receive the additional case mix factor regardless of the 70th percentile maximum rate.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

B. Nursing Facilities That Provide Intermediate Care, Including Intermediate Care for People with Mental Illness Aged 65 and Older (Cont.)

2. Accounting Procedures (Cont.)

b. Maximum Allowable Rate Ceiling (Cont.)

Effective July 1, 2000, the 70th percentile maximum rate is established based on facility costs from the June 30, 2000, compilation of costs.

The allowable cost is the actual audited reported cost plus the inflation factor and incentive factor, subject to the maximum allowable cost ceiling.

For non-state-owned nursing facilities, an occupancy factor is used determining the reimbursement rate for the facility. Typically the per diem is arrived at by dividing the actual allowable reported costs by total patient days during the reporting period. For purposes of rate determination, total patient days are actual inpatient days or 80 percent of the licensed capacity of the facility, whichever is greater.

Facilities falling below 80 percent occupancy shall have all costs not related to patient care service costs divided by 80 percent their licensed capacity.

Effective July 1, 2000, the owner-administrator compensation limits are $3,175 per month plus $33.87 for each bed over 60, for a maximum compensation not to exceed $4,704 per month. These limits are adjusted July 1 of each year and increased or decreased by the inflation factor applied to facility rates.

Facilities using Medicare cost reports have rates at their SNF rate or the NF maximum, whichever is lower.

c. Inflation Factor

An inflation factor is applied in determining the prospective payment rates, reflecting the anticipated economic conditions and trends during the payment period. The inflation factor is applied in determining rates for all nursing facilities.

The inflation factor shall not exceed the percent increase in the Consumer Price Index for all urban consumers, U.S. city average, for the prior year ending December 31.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

B. Nursing Facilities That Provide Intermediate Care, Including Intermediate Care for People with Mental Illness Aged 65 and Older (Cont.)

2. Accounting Procedures (Cont.)

d. Incentive Factor

The incentive factor is determined at the beginning of each state fiscal year based upon the latest June 30 report of "Unaudited Compilation of Various Costs and Statistical Data."

The incentive factor is 1/2 of the difference between the forty-sixth percentile of allowable costs and the seventy-fourth percentile of allowable costs. Under no circumstances shall the incentive factor be less than $1 per patient day or more than $1.75 per patient day.

e. Case Mix Factor

Effective July 1, 2000, a semi-annual case mix factor is applied to the payment rates for the following facilities:

- Facilities with a case mix index derived from the MDS reports that exceeds the Iowa nursing facility average and with patient care service costs that exceed the average for all participating nursing facilities receive an addition to their payment rate of $5.20 per day.

- Facilities with a case mix index that exceeds the Iowa nursing facility average and with patient care service costs that are less than the average for all participating facilities receive an addition to their payment rate of $2.60 per day.

Iowa Department of Human Services

FINANCIAL AND STATISTICAL REPORT

Facility Name	Federal ID Number	Vendor Number	
Street	City	State	Zip
Period of Report From To	Fiscal Year Ending Mo Day Year		County
Date Facility Entered Program	Date Owner Acquired Facility		

Type of Control (check only one)

GOVERNMENT
- ❑ State
- ❑ County
- ❑ Other

NONPROFIT ORGANIZATION
- ❑ Church-Operated
- ❑ Church-Related
- ❑ Other Nonprofit

PROPRIETARY
- ❑ Individual
- ❑ Partnership
- ❑ Corporation
- ❑ "S" Corporation

Accounting Basis: ❑ Accrual ❑ Modified Cash ❑ Cash

Ownership Information

Name of Owner	% of Work Week Devoted to Business	Title	Salaries and Wages	Social Security Number	% of Ownership in Home

NOTE: Attach additional schedules as necessary to complete ownership information.

Number of Medicaid Recipients at End of Period _____

Statistical Data

	# Authorized Beds Beginning Period	# Authorized Beds End of Period	Total Bed Days Reporting Period	Total Patient Days Reporting Period	Percent Occupancy Col. 4 ÷ 3	Number of Admissions	Number of Discharges
NF							
RCF							
SNF							
ICF/MR							
RCF/MR							
Total							

An opinion of a certified public accountant of the fairness of presentation of operating results or revenues and expenses (is, is not) attached. Questions concerning financial data included in this report should be directed to:

_____ Telephone ( ) _____

Certification Statement

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and imprisonment under state or federal law.

I CERTIFY that I have read the above statement and that I have examined the accompanying cost report and supporting schedules. To the best of my knowledge and belief, it is a true and complete statement prepared from the records of the provider in accordance with applicable instructions. I further certify that costs have been properly allocated between or among programs and that no cost has been reported more than once as a reimbursable cost.

Signature of Officer or Administrator of Facility	Date

Error

An error occurred while processing this page. See the system log for more details.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE B

EXPENSE ADJUSTMENTS			ENTER IN COLUMN 3, SCHEDULE C Adjustment Amount	Line(s) #
NONREIMBURSABLE EXPENSES:				
Provisions for income tax				92
Fees paid Board of Directors				94
Nonworking officers' salaries				95
Travel and entertainment. See instructions.				16
Donations				97
Expenses of nonparticipating facilities				
Fund-raising expenses				
Pharmacy, drugs, and medications				73
Insurance premiums on life of officer, owner				93
Other expenses not related to resident care				
EXPENSE LIMITATIONS:				
Salaries of owners and related parties. See instructions.				
Position	**Paid**	**Allowable**		
Administrator	$	$		1
Assistant administrator				2
Management fees				13
Nursing director				40
Other				
Services, facilities, supplies furnished by organizations related to the facility by common ownership or control				
	Paid	**Allowable**		
Rental equipment	$	$		
Services and supplies (describe)				
Rental of facility. See instructions.	(1)	(2)		
Payments				
Lessor's cost:				
Depreciation				
Interest				
Property tax				
Other				
Return on equity				
Reduction - Column 1 less than column 2				84
Advertising expense in excess of the lesser of $3,600 or an amount computed at 2% of routine daily revenue				17
Allowable depreciation from Schedule D and D-1				81
Interest expense on loans from partners, proprietors, stockholders, or organizations. See instructions.	**Expense** $	**Allowable** $		85

Facility	Vendor No.
Period of Report: From	To

SCHEDULE B

EXPENSE ADJUSTMENTS (Cont.)			ENTER IN COLUMN 3, SCHEDULE D	
			Adjustment Amount	Line(s) #
EXPENSE ADDITIONS: Compensation of nonsalaried proprietors and partners or members of religious orders	Paid	Allowable		
Administrator	$	$		1
Nursing director				40
Other				
TOTAL				

Note: Enter adjustments on Schedule C on the line for the expense center affected.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE C - PART 1

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	ADMINISTRATIVE COSTS (1)				
1	Administrator wages				
2	Business office wages				
3	Employer's taxes (Admin.)				
4	Group health, life, and retirement benefits (Admin.)				
5	Worker's comp. insurance (Admin.)				
6	Employment advertising and recruitment (Admin.)				
7	Criminal record checks (Admin.)				
8	Education and training (Admin.)				
9	Supplies (Admin.)				
10	Telephone				
11	Equipment rental (Admin.)				
12	Home office costs				
13	Management fees				
14	Accounting costs, legal, and other professional fees				
15	General liability insurance				
16	Travel, entertainment, and auto				
17	Advertising and public relations				
18					
19	**TOTAL ADMINISTRATIVE COSTS**				
	ENVIRONMENTAL SERVICES (1)				
20	Laundry wages				
21	Housekeeping wages				
22	Maintenance wages				
23	Employer's taxes (Environ.)				
24	Group health, life, and retirement benefits (Environ.)				
25	Worker's comp. insurance (Environ.)				
26	Employment advertising and recruitment (Environ.)				
27	Criminal record checks (Environ.)				
28	Education and training (Environ.)				
29	Supplies, laundry				
30	Supplies, housekeeping				
31	Supplies, maintenance				
32	Utilities				
33	Purchased services, laundry				
34	Purchased services, housekeeping				
35	Purchased services, maintenance				
36	Equipment repairs				
37	Equipment rental (Environ.)				
38					
39	**TOTAL ENVIRONMENTAL SERVICES COSTS**				

Facility	Vendor No.

SCHEDULE C - PART 1 (Cont.)

ALLOCATION OF EXPENSES OF FACILITIES PROVIDING MULTILEVEL CARE

Allocation Basis	ICF	RCF	SNF	ICF/MR	RCF/MR	Total Equal Column 4	Line
							1
							2
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Facility	Vendor No.
Period of Report: From	To

SCHEDULE C - PART 2

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	PATIENT CARE SERVICE COSTS (1)				
	Direct Patient Care Costs				
40	D.O.N wages				
41	R.N. wages				
42	L.P.N. wages				
43	C.N.A. wages				
44	Rehabilitation wages				
45	Activities wages				
46	Social service wages				
47	Employer's taxes (Dir. Health)				
48	Group health, life, and retirement benefits (Dir. Health)				
49	Worker's comp. insurance (Dir. Health)				
50	Employment advertising and recruitment (Dir. Health)				
51	Criminal record checks (Dir. Health)				
52	Education, training (Dir. Health)				
53	Certified nurse aide training				
54	Contracted professional social services				
55	Professional support services				
56	Contracted nursing services				
57	Contracted rehabilitation services				
58					
59	**TOTAL DIRECT PATIENT CARE COSTS**				
	Support Care Costs				
60	Medical record wages				
61	Medical director				
62	Dietary service wages				
63	Employer's taxes (Support)				
64	Group health, life, and retirement benefits (Support)				
65	Worker's comp. insurance (Support)				
66	Employment advertising and recruitment (Support)				
67	Criminal record checks (Support)				
68	Supplies, patient care services				
69	Supplies, dietary services				
70	Supplies, activities				
71	Supplies, social services				
72	Food and nutritional supplements				
73	Pharmacy services				
74	X-Ray services				
75	Laboratory				
76	Professional support services				
77	Equipment rental (Patient Care)				
78					
79	**TOTAL SUPPORT CARE COSTS**				
80	**TOTAL PATIENT CARE SERVICE COSTS**				

Facility	Vendor No.

SCHEDULE C - PART 2 (Cont.)

ALLOCATION OF EXPENSES OF FACILITIES PROVIDING MULTILEVEL CARE

Allocation Basis	ICF	RCF	SNF	ICF/MR	RCF/MR	Total Equal Column 4	Line
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Facility	Vendor No.
Period of Report: From	To

SCHEDULE C - PART 3

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	PROPERTY COSTS (1)				
81	Depreciation (2)				
82	Amortization				
83	Real estate taxes				
84	Facility lease				
85	Interest				
86	Property and casualty insurance				
87	Building and grounds repairs				
88					
89	**TOTAL PROPERTY COSTS**				
	OTHER COSTS				
90	Beauty and barber shops				
91	Personal purchases for residents				
92	Income taxes				
93	Officer's life insurance				
94	Director fees				
95	Nonworking officers' salaries				
96	Professional care (Physicians)				
97	Contributions				
98					
99	**TOTAL OTHER COSTS**				
100	**TOTAL OF ALL EXPENSES (3)**				

(1) Costs allocated to certain items are limited. See the instructions for Schedule B for a list and explanation.

(2) Depreciation in Column 1 must agree with total buildings and equipment amount from Schedule D.

(3) Total expenses in Column 1 must be entered on Schedule F, Reconciliation of Equity.

TN No. MS-0010
Supersedes TN # MS-99-10

NOV 9 2000
Approval Date

JUL 1 2000
Effective Date